Printed: 12/09/2015 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	17E071			B. WING		12/09/2015	
	OVIDER OR SUPPLIER  COUNTY HOSPITAL	LTCU	STREET ADDRE	SS, CITY, STAT			
GKELLET	COUNTYTIOSPITAL	LIGO		E, KS 6787			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	H CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE	
F 000	INITIAL COMMENTS			F 000			
	The following citations Health Resurvey.	s represent the findings	s of a				
	483.10(b)(11) NOTIF (INJURY/DECLINE/R			F 157			
	consult with the reside known, notify the reside or an interested family accident involving the injury and has the pot intervention; a signific physical, mental, or publications are intervention in health status in either life three clinical complications significantly (i.e., a new existing form of treatments); or a decist the resident from the \$483.12(a).  The facility must also and, if known, the resor interested family mechange in room or root accidents.	dent's legal representary member when there is resident which results tential for requiring physicant change in the resides ychosocial status (i.e. a, mental, or psychosocial eatening conditions or a); a need to alter treatment due to adverse commence a new form ion to transfer or dischafacility as specified in promptly notify the resident's legal representatember when there is a symmate assignment as	tive s an in sician lent's , a ial nent of arge				
	specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.						
	the address and phor	rd and periodically upd ne number of the reside r interested family men	ent's				
LABORATON	The facility had a cen	not met as evidenced b sus of 28 residents. Th WSUPPLIER REPRESENTATIV	e		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

, ,		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	VOLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	17E071 B. WING 12/09/201		9/2015					
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
GREELEY	COUNTY HOSPITAL	LTCU		O ST PO BO IE, KS 6787				
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 157	facility failed to notify representative for Researding resident to Resident #32's physic movements for several Findings included:  - Resident #28's adm Data Set assessment the resident had a (Bl Mental Status score of the resident had severe of MDS indicated the resident had severe of MDS indicated the resident required extensive (ADLs) Activities of D.  The 3/16/15 care plant a wheelchair for mobil him/herself around the instructed staff to reoresident as needed, a when the resident beginnereased negative beginnereased negative beginnereased negative beginnereased with the residents and if the beginnereased with the indicated the staff had family or physician of The 4/24/15 facility rewas pushing Resident residents residents and if the beginning residents and family or physician of The 4/24/15 facility rewas pushing Resident	esidents. Based on eview, and interview the the physician and legal sident #27 and #28 resident altercations, a cian regarding lack of bal days.  Inission (MDS) Minimum and day	nd owel  n ed ne s, used an se t #27 r vo e two uld #28's	F 157				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	E CONSTRUCTION	(X3) DATE SUR COMPLETE	
	17E071			B. WING		12/09	9/2015
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STAT	TE, ZIP CODE		
GREELEY	COUNTY HOSPITAL	. LTCU		ST PO BO E, KS 6787			
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F 157	room, Resident #27 his/her head, with his indicated the staff haphysician of the incident #25 physician of the incident #25 physician of the incident #25 physician of the incident #26 proceeded to slap the across the face. The #28 covered his/her "he/she is gonna kill staff had not notified of the incident.  The 5/23/15 at 7:20 Resident #27 pushed wheelchair in the halfound the Resident #27 pushed wheelchair in the halfound the Resident #27 had hit his/her fist, and it hum. The 5/23/15 facility in had been pushing Rewheelchair, and an aby himself/herself, correport indicated the resident #27 had hit the head, and it hum staff had not notified physician of the incident physician	hit the Resident #28 on sher hand. The report and not notified the family dent.  eport indicated on 5/9/12 was standing by the factor was wrong and the physical was wrong. The notion of the factor was wrong. The notion was wrong and in a panic. The eport indicated Resident was wrong and in a panic. The resident told the aide thim/her, with his/her fish the resident's family or dent.  AM, observation reveals	5 at facility in a go sed and es, and es aide er aide er, and es aide et, and es et	F 157			
	Resident #28 propel						

		ROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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GREELEY COUNTY HOSPITAL LTC	CU		ST PO BO E, KS 6787				
PREFIX (EACH DEFICIENCY MUST BE				PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 157 Continued From page 3 Resident #27, who was so his/her wheelchair, and Repushed Resident #28's whim/her.  On 12/3/15 at 2:29 PM, A stated he/she would have the resident's legal represafter each incident.  The facility's 7/20/15 Noting policy stated the facility slinformed of resident's meappointments, incidents of information. The policy stated the facility slinformed of resident's meappointments, incidents of information. The policy stated family member who was notified and what in a progress note in the resident, their legal represinterested family member who was notified and what in a progress note in the resident #27's (POS) P dated 11/30/15, indicated diagnoses of anxiety (a feabout what might happen (high blood pressure), definitellectual faculties such concentration, and judger organic disease or disord.  The admission (MDS) Minassessment, dated 4/20/1 had a (BIMS) Brief Intervi	seated on a couch, we Resident #27 gently wheelchair away from Administrative Nurse expected staff to me sentative and physical fification of Changes should keep families edical/mental status, or other pertinent stated staff will notify when applicable, the esentatives and any ers. Staff will docume that time they were not resident's chart.  By the legal representation that they were not resident's chart.  By the legal representation that they were not resident's chart.  By the legal representation of the above incided they impaired Resident had fear or nervousness on), and hypertension the mentia (deterioration as memory, ement, resulting from the der).  By the legal representation of the resident had fear or nervousness on), and hypertension the mentia (deterioration as memory, ement, resulting from the der).  By the legal representation of the resident had fear or nervousness on), and hypertension the mentia (deterioration as memory, ement, resulting from the der).  By the legal representation of the resident had fear or nervousness on), and hypertension the resident had fear or nervousness on), and hypertension the resident had fear or nervousness on the resident had fear or nervousn	e A notify cian by ent otified tative ents, lent et, on of an an sident	F 157				

l' '		` ,	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
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F 157	cognition. The assess resident required limit member for bed mobin hygiene. The assess resident wandered 4 rejected care 1 to 3 d. The 1/27/15 Behavior Assessment indicated almost continuously, talked about wanting CAA further stated the other resident's room. The quarterly MDS, dresident had a BIMS severely impaired cogrevealed the resident assistance of 1 staff root transfers, dressing, to hygiene. The assess resident wandered da The 4/23/15 care plant a diagnosis of demen questions several time. The care plan lacked interventions to assist behaviors.  The 4/23/15 at 2:36 For resident hit Resident in the residents and the residents and the residents and the residents. Review	sment further revealed to dead assistance of 1 stafflity, dressing and personent further revealed the foliation of the foliation of the resident wandered checked all the doors, at the resident wandered on the resident wandered out the facility. The eresident wandered out to leave the facility and required extensive member for bed mobility sileting and personal ment further revealed the fully and had no behavior of the revealed the resident tia, and may ask the safes, but is easily redirect direction to staff for the with the resident's extensive the staff separated the dead the staff separated the dead the staff separated the dead the was counseled as wo of the medical recording, and family were not	f onal ne d d and e d d d d d d d d d d d d d d d d d d	F 157				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		A. BUILDING	E CONSTRUCTION	(X3) DATE S COMPLI	
		17E071		B. WING		12	09/2015
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GREELE	COUNTY HOSPITAL	LTCU		ST PO BO E, KS 67879			
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F 157	The 4/24/15 at 2:36 resident was pushing wheelchair into the control stated the resident has eparated the two restaff counseled their Review of the medic physician and family incident.  The 4/24/15 facility resustained by either rewill monitor the resident was standing Resident #28 wheeled Resident #28 voiced home". Resident #28 voiced home". Resident #28 up" and proceeded to times when he/she of wanted to go home. Resident #28 covered "he/she is going to keep the two resident #27 distance from Resident #28 distance from Resident #27 distance from Resident #28 distance from Resident #28 distance from Resident #28 distance from Resident #28 distance from Resident #27 distance from Resident #27 distance from Resident #28 distance from Resident #28 distance from Resident #27 distance from Resident #27 distance from Resident #28 distance from Resident #27 distance from Resident #27 distance from Resident #28 distance from Resident #27 distance from Resident #28 distance from Resident #27 distance from Resident #28 distance from Resident #27 distance from Resident #28 distance from Resident #27 distance from Resident #28 distance from Residen	PM, nurse's note stated g Resident #28 in his/her dining room. The note further than the state of the state o	ricther ff d the chers.  ries e staff stact  he nen air. so go shut ltiple d, ted  //her he amily es ected I. the 28,	F 157			

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER  COUNTY HOSPITAL	LTCU	506 3R	RESS, CITY, STA D ST PO BO NE, KS 6787	X 338		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 157	Resident #28 stated In him/her in the head. In head hurt from where hospital staff assessed was found. The note to resident's have been distance from one and record revealed the postified of the incident. The 5/23/15 facility rewas unwitnessed and Resident #28. The rephave a diagnosis of district which resident investion. The 5/24/15 at 7:54 President hit Resident hit Resident hit Resident hit Resident hit Resident hit Resident hit record revealed the postified of the incident completed.  On 12/1/15 at 1:30 President ambulating distaff, "what can I do?"	ent #28 what was wron Resident #27 punched Resident #28 stated his. The ed the resident and no infurther stated the two encouraged to keep the other. Review of the me hysician and family went.  Port concluded the incident in injuries found on port stated both resider ementia and unsure as igated the incident.  My nurse's note stated in the from Resident #28 aftent #28 on the face and Review of the medical hysician and family went and no incident report.  My observation revealed lown the hallway asking Further observation	/her njury eir edical re not  dent  dt's to  staff ter d told re not t was	F 157			
	On 12/3/15 at 12:41 F the resident has had	was smiling and pleasa PM, Licensed Nurse B s problems with Resident ent but stated the reside g like that recently.	stated t #28				
	resident has not had	PM, Nurse Aide K stated any inappropriate beha rould get the nurse if the	vior				

` '		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	JLIA .		LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
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F 157	Continued From page	e 7		F 157				
	resident was not easi	ly redirected.						
		M, Administrative Nurse and family should be no sident altercations.						
	The 8/23/06 facility's Notification of Change Policy was to keep families informed of resident's medical and mental status incidents or other pertinent information. The policy further stated the resident's physician would be notified of all non emergent notification questions or concerns of a resident's medical status by communication sheet faxed to the clinic.							
		otify Resident #27's fan /she had been involved sident altercations.						
	- Resident #32's med facility admitted the re	dical record revealed the esident on 8/11/15.	е					
	The (POS) physician's order sheet, dated 9/18/15, revealed the resident had a diagnosis of constipation (bowel movements that are infrequent or hard to pass).		sis of					
	had a (BIMS) Brief Int score of 14. The asse resident required limit member for bed mobi dressing, and persona further revealed the re continent of bowel.	17/15, indicated the resterview for Mental Statuessment revealed the ted assistance of 1 stafflity, transfers, toileting, al hygiene. The assess	us f ment					

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	ROVIDER OR SUPPLIER  / COUNTY HOSPITAL	LTCU	506 3RI	RESS, CITY, STA D ST PO BO NE, KS 6787	X 338		
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F 157	resident had long and problems with severe assessment revealed extensive assistance transfers, toileting, dru hygiene. The assess resident was occasion. The 8/13/15 care plan have constipation and the resident per the toplan lacked direction management.  The 8/11/15 physician the staff to administer (MOM) Milk of Magne constipation) 30 (cc) with breakfast, if no beneated into the rectubedtime, if the resident movement for 4 days. The order further dire physician if no bowel. The October Bowel Mono documentation the movement from 10/1/consecutive days).  The November Bower revealed no document from consecutive days) and 11/18/15 to 11/27/15 (The October and Novement Movement Move	I short term memory ly impaired cognition. The resident required of 3 for bed mobility, essing, and personal ment further revealed the hally incontinent of bown a stated the resident did directed the staff to to bileting schedule. The cofor the staff regarding both a standing orders directed the following: esium, (a laxative for coubic centimeters, by mowel movement for 3 days, (a laxative for constipation) rectally, once at that has not had a bowel control of the staff to notify the movement for 5 days.  Ilovement Record reveate resident had a bowel 15 to 10/15/15 (15	ne rel. I not ilet rare rowel ed nouth, ays. ation he aled a 15 from	F 157			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER			` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRI	ESS, CITY, STA	TE, ZIP CODE	•		
GREELEY	COUNTY HOSPITAL	LTCU		ST PO BO E, KS 6787				
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F 157	provided physician or resident for the lack of outlined in the physician or resident for the lack of outlined in the physician of the physician of the provided for the provided for the resident of the resident.  On 12/2/15 at 4:37 Pt chart bowel movement for the resident of the physician for the computer system a resident has not had days and the nurse in the resident had not frover 5 days.  The Facility's undated the physician Policy direct emergent notifications a resident's medical statement of the physician product of the physician prod	dered interventions to the flower elimination, as an standing orders.  M, observation revealed on his/her right side, Nursonal hygiene on the elimination disposable incontinentis/her knees, and covered to the flower elimination of the elimin	d the arse t pad, ered staff tem. have y the ated hen fter 3 ers. e A hen for	F 157				
	of bowel movement.  483.13(c)(1)(ii)-(iii), (c) INVESTIGATE/REPC ALLEGATIONS/INDIX  The facility must not 6	RT	have	F 225				

OD3B11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
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F 225	been found guilty of a mistreating residents had a finding entered registry concerning all of residents or misapp and report any knowle court of law against a indicate unfitness for other facility staff to the or licensing authoritie.  The facility must ensuinvolving mistreatmen including injuries of unisappropriation of reimmediately to the add to other officials in act through established postate survey and cert. The facility must have violations are thorough prevent further potent investigation is in profit to the administrator or representative and to with State law (includicertification agency) vincident, and if the all	abusing, neglecting, or by a court of law; or hat into the State nurse aid buse, neglect, mistreatropropriation of their propedge it has of actions ben employee, which wouservice as a nurse aide register.  The state nurse aide register is a nurse aid	de ment erty; y a uld e or istry tions oorted y and v o the ed hust orted dance and f the d	F 225				
	The facility had a cen sample included 13 re observation, record re	not met as evidenced but sus of 28 residents. The esidents. Based on eview, and interview the altercations involving	e					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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GREELEY COUNTY HOSPITAL	LTCU		ST PO BO E, KS 6787				
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Data Set assessment, the resident had a (BI Mental Status score 0 resident had severe or MDS indicated the resident required extensive (ADLs) Activities of Data The 3/16/15 behavior Assessment indicated diagnosis of demential disorder characterized confusion), family only Xanax (an antianxiety The assessment indicated and asked to go home profanity names but is The 3/16/15 care plant a wheelchair for mobil him/herself around the instructed staff to reor resident as needed, a when the resident bed increased negative bed The 4/23/15 facility rehit Resident #28 on to Resident #28 hit the rehand. The report indicincidents of physical a residents and if the bed be addressed with the	assion (MDS) Minimum, dated 3/16/15, indicated MS) Brief Interview of the ognitive impairment. The sident had no behaviors e staff assistance with aily Living.  (CAA) Care Area If the resident had a confidence in comparities in the resident had a confidence in the resident want of	ted the s, d. dered ted. used used the see two uld the	F 225				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1, ,	LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
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	Continued From page called to the state age.  The 4/24/15 facility rewas pushing Resident down the hallway, whroom, hit the resident hand. Review of the rincident was not called.  The 5/11/15 facility revised and Resident #2 cafe and Resident #2 wheelchair stated, much home". The note indicate his/her voice, told Resproceeded to slap the across the face. The across the face. The across the face. The covered his/her head "he/she is going to kill record revealed the instate agency.  The 5/23/15 at 7:20 F. Resident #27 pushed wheelchair in the hall found Resident #28 co.	e 12 ency.  port indicated Resident #28 in his/her wheelchen they arrived at the don his/her head with himedical record revealed to the state agency.  port indicated on 5/9/157 was standing by the f8 wheeled by him/her in ultiple times "I want to go cated Resident #27 rais sident #28 to "shut up", a resident multiple times note indicated Resident	t #27 hair, lining is/her If the  5 at facility n a go sed and s t #28 edical o the  ed er aide nd		CROSS-REFERENCED TO THE AI		DATE	
	indicated Resident #2 had hit him/her on the hurt. Review of the m incident was not called. The 5/23/15 facility rehad been pushing Rewheelchair, and an ai himself/herself crying indicated the resident had hit him/her, with hit hurt. Review of the	28 told the aide Resider the head with his/her fist, edical record revealed d to the state agency.	ant #27 and it the  t #27 by cort #27 and					

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F 225	Resident #28 propelle wheelchair into the concept Resident #27, who was Resident #27 gently prochair away from him/h. On 12/3/15 at 7:53 Affiverified the resident to not called to the state. The facility's 11/17/20 policy stated all reside to be free from abuse. The policy stated all a mistreatment, neglect injuries of unknown so for resident property was unit of the state. The facility failed to resident discovery kDOA(Kansas Depart clarification) and to all by the risk manager of the facility failed to resident #28, who was	AM, observation revealed him/herself in a commons area, backed in as seated on a couch, a coushed Resident #28's control of the incident as performed and management of the incident as performed to the second and the	nto and wheel e A were right ion. ring l ation ate (as 4 uired	F 225			
	dated 11/30/15, indicadiagnoses of anxiety about what might hap	(a fear or nervousness pen), and hypertensior , dementia (deterioratio	1				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			E CONSTRUCTION	(X3) DATE SI COMPLE	
	17E071		B. WING		12/	09/2015
NAME OF PROVIDER OR SUPPLIER			ESS, CITY, STAT			
GREELEY COUNTY HOSPITAL L	LTCU		ST PO BO E, KS 67879			
PREFIX (EACH DEFICIENCY MUST	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REG OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE
F 225 Continued From page concentration, and jud organic disease or discontration (MDS) assessment, dated 4/2 had a (BIMS) Brief Intescore of 0 which indicated almost continuously. The assessment wandered 4 to rejected care 1 to 3 data and the other resident's room.  The 1/27/15 Behavior Assessment indicated almost continuously, continu	Igement, resulting from order).  Minimum Data Set 20/15, indicated the receive for Mental Statisticated severely impaired ment further revealed ed assistance of 1 statisty, dressing and personent further revealed the 6 days a week and ays a week.  (CAA) Care Area the resident wandered the checked all the doors, so leave the facility. The resident wandered out the resident further revealed the resident wandered the resident wand may ask the sates, but is easily redirect direction to staff for with the resident's	sident us I the ff onal ne d and e ut of ed the ted nt y, ne ors. had ame eted.	F 225			

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	T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		17E071			B. WING 12/0			
GREELEY COUNTY HOSPITAL LTCU 50			506 3RD	RESS, CITY, STA D ST PO BO IE, KS 6787	X 338	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY  OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 225	residents and the resistriking others. Revier revealed the physician notified of the incident.  The 4/24/15 at 2:36 Fresident was pushing wheelchair into the distated the resident his separated the two resistaff counseled the resident was pushing wheelchair into the distated the resident his separated the two resistaff counseled the resident was fresident.  The 4/24/15 facility resustained by either rewill monitor the resident will monitor the resident physician should.  The 5/9/15 at 7:52 President was standing Resident #28 wheele Resident #28 wheele Resident #28 voiced, home". Resident #27 up" and proceeded to times when he/she diwanted to go home. Resident #28 covered "he/she is going to kill the two resident's and assessed and no injustated Resident #27 distance from Reside that it was not nice to	ident was counseled above of the medical record in, and family were not in, and family were not in.  PM, nurse's note stated a Resident #28 in his/he ining room. The note furth the Resident #28 and staff sidents. The note stated is idents. The note stated is ident about striking of all record revealed the were not notified of the export concluded no injurtive in the behaviors and conthe behaviors and conthe behaviors reoccur.  M, nurse's note stated the phy the dining room who is the behaviors reoccur.  M, nurse's note stated the phy in his/her wheelch multiple times, "I want told Resident #28 to "so is slap Resident #28 to "so is slap Resident #28 multiple times," I want told Resident #28 multiple times, "I want told Resident #28 multiple times, "I want told Resident #28 multiple times," I want told Resident #28 multiple times, "I want told Resident #28 multiple times," I want told Resident #28 multiple times, "I want told Resident #28 multiple times," I want told Resident #28 multiple times, "I want told Resident #28 multiple times," I want told Resident #28 was any was found. The note was told to keep his/her that #28 and staff to him/o hit people. Review of tilled the physician and fall records.	the r rther of the hers.  ries estaff tact he hen air. to go hut liple he d, ted	F 225				

(X2) MULTIPLE CONSTRUCTION

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	LE CONSTRUCTION	(X3) DATE SUI COMPLET	
		17E071		B. WING	<del></del>	12/0	9/2015
	0.4050.00.00.000.050		CTDEET ADDI	<b>I</b> RESS, CITY, STA	TE ZID CODE	1 .2/3	0,2010
	OVIDER OR SUPPLIER	LTOU					
				OST POBO IE, KS 6787			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225	The 5/9/15 facility repsustained by either rethe staff to keep the to The 5/23/15 at 7:16 F staff found the resider who was crying and in the staff asked Resident #28 stated F him/her in the head. F head hurt from where hospital staff assesse was found. The note fresident's have been distance from one and record revealed the instate agency.  The 5/23/15 facility rewas unwitnessed and Resident #28. The rephave a diagnosis of d which resident investion. The 5/24/15 at 7:54 F separated the resident the resident hit Residhim/her to "shut up". If record revealed the instate agency.  On 12/1/15 at 1:30 President ambulating distaff, "what can I do?" revealed the resident	ort concluded no injurie sident involved and dire wo residents separated and no residents separated and not pushing Resident #2 notes a panic. The note state and #28 what was wrong Resident #27 punched Resident #28 stated his he/she was hit. The did the resident and no infurther stated the two encouraged to keep the other. Review of the medical notes in an and unsure as gated the incident.  In My nurse's note stated and the incident was not called the incident.  In My nurse's note stated and the incident was not called the incident.  In My nurse's note stated and the incident was not called the incident was not	ected the 8, ted, g. /her njury eir edical to the dent atts to staff ter d told to the	F 225			
		M, Administrative Nurse o resident altercations v					

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER					(X3) DATE SURVEY COMPLETED	
		17E071		B. WING		12/0	9/2015
GREELEY COUNTY HOSPITAL LTCU 506				RESS, CITY, STATE D ST PO BO NE, KS 6787	X 338		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	stated the policy of th have the right to be fr exploitation and will be survey and certification possible.  The facility failed to receive the Resident #27, who his times and on several state agency.  483.15(f)(1) ACTIVIT INTERESTS/NEEDS	e agency.  S Abuse and Neglect Pore facility was all resider ree from abuse, neglect ree reported to the state on agency as soon as report altercations involved the another resident multiple different occasions to the state of the state of the state on agency as soon as report altercations involved the state of the	nts i, and ring ple he	F 225			
	of activities designed the comprehensive as the physical, mental, of each resident.  This Requirement is The facility had a cen sample included 13 reviewed for activities record review and interprovide an ongoing provide activities and the psychosocial well-bei were aware of activitie attendance for 5 of the activities (#27, #32, #Findings included:	ng and ensure resident es, and offered activity e 5 residents reviewed	e with s and being by: e e e e n, d to meet es for				

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	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E071		B. WING		12/0	9/2015	
	NAME OF PROVIDER OR SUPPLIER  GREELEY COUNTY HOSPITAL LTCU			RESS, CITY, STA DIST PO BO IE, KS 6787	X 338	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY  OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)		
F 248	books, newspapers, g are somewhat import MDS further indicated important to the resid	group activities and mus ant to the resident. The d that animals are very lent.	,	F 248				
	Resident #27's quarterly MDS, dated 10/18/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 3 which indicated severely impaired cognition. The assessment revealed the resident required extensive assistance of 1 staff member for bed mobility, transfers, dressing, toileting, and personal hygiene.							
	The admission 1/27/15 Activity (CAA) Care Area Assessment did not trigger.  The 10/19/15 care plan stated the resident wandered around the facility all day and loves to help. The care plan stated the resident will ask many times a day what he/she can do to "help". The care plan further directed the staff to invite and take the resident to all activities 4-5 times a week.		es to sk elp". ite					
	revealed the resident the month.  The 10/20/15 untimed	Activity Participation lo attended 5 activities du d quarterly activity revie ill sit during an activity forwalk a lot.	ew					
		ctivity Participation log attended 9 activities du	uring					

(X2) MULTIPLE CONSTRUCTION

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E071		B. WING		12/09		
	OVIDER OR SUPPLIER  COUNTY HOSPITAL	LTCU	506 3RI	RESS, CITY, STA DIST PO BO IE, KS 6787	X 338	·		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 248	The November 2015 revealed the resident the month.  On 12/1/15 at 1:30 President ambulating unasking, "What can I do scrabble tile tree ornations on 12/1/15 at 3:30 President ambulating unasking, "What can I do On 12/2/15 at 10:30 President ambulating unasking, "What can I do On 12/2/15 at 10:30 President ambulating unasking, "What can I do On 12/2/15 at 10:30 President ambulating and I do I a scrabble tile tree ornations of the I and I do I and I do I and I	Activity Participation log attended 7 activities du M, observation revealed p and down the halls do?"  M, observation revealed PM scheduled activity faments.  M, observation revealed p and down the halls	d the d no inish d the ed the and	F 248	DEFICIENCY)			
	told he/she could have get him/her when it we resident did not receive. On 12/2/15 at 3:13 Pthe/she doesn't have rewith dementia (a chrothe mental processes injury and marked by personality changes,  On 12/2/15 at 1:45 Pthe	g room. The resident we re nail care and staff we as his/her turn but the ve nail care.  M, Activity Staff C state many activities for residentic or persistent disords caused by brain disease memory disorders, and impaired reasoning.  M, Administrative Nursecould have more activities	ould d lents ler of se or g)					

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	17E071			B. WING	<del></del>	12/09/2015	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GREELEY	COUNTY HOSPITAL	LTCU		O ST PO BO IE, KS 6787			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLET	TION
F 248	Continued From page	e 20		F 248			
	facility will ensure an activities designed to resident's interests to mental, and physical his/her comprehensiv	accommodate the indiv help his/her physical, well-being according to re assessment.  ffer, remind, and assist and activities, and provid ce with the resident's					
	- Resident #32's quarterly (MDS) Minimum Data Set assessment, dated 11/17/15, indicated the resident had long and short term memory problems with severely impaired decision making skills. The assessment indicated the resident required extensive assistance of 2 staff members for bed mobility, transfers, and ambulation on and off the unit, dressing, toileting and personal hygiene.						
	The admission MDS dated, 8/11/15, indicated it was very important to attend his/her favorite activities, church, and pets and was somewhat important to attend group activities.						
		are Area Assessment fo esident does not attend					
	would attempt to atter a week and would co	an indicated the residen nd 1 to 2 activities of ch ntinue to visit with his/h nily members. The care	oice er				

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE				(X3) DATE SURVEY COMPLETED	
	17E071			B. WING		12/0	09/2015
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
				D ST PO BO NE, KS 6787			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 248	Continued From page	e 21		F 248			
	further stated the resi	dent enjoyed sports on d watching the news be					
	The 8/11/15 activity review indicated the resident would like to attend church, devotions and communion.						
	revealed the resident	The September 2015 Activity participation log revealed the resident did not attend any activities but received foot care 3 times that month.  The October 2015 Activity participation log revealed the resident did not attend any activities but had 2 times of individual activities.  The 11/13/15 quarterly review revealed the resident enjoyed foot care, attended bingo a couple of times, and was very personable.  The November 2015 Activity participation log revealed the resident attended 1 activity during the month.					
	revealed the resident						
	resident enjoyed foot						
		M, observation revealed with his/her eyes closed					
	recently the resident hactivities because he/	M, Nurse Aide D stated has not left his/her roon /she was too weak. Nur ident's spouse visits the	n for se				
		M, Activity Staff C state any 1:1 or any type of	d				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E071		B. WING		12/09/2015	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
GREELEY	COUNTY HOSPITAL	LTCU		ST PO BO E, KS 6787			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 248	Continued From page 22 activity with the resident since he/she stopped coming out of his/her room.			F 248			
	On 12/3/15 at 1:45 PM, Administrative Nurse A stated staff should do more 1:1 activities with the resident. Administrative Nurse A further stated the resident's spouse and family visit with the resident daily.						
	The 7/20/15 facility Activity Policy stated the facility will ensure an ongoing program of activities designed to accommodate the individual resident's interests to help his/her physical, mental, and physical well-being according to his/her comprehensive assessment.						
	The facility failed to offer, remind, and assist Resident #27, to attend activities, and provide activities in accordance with the resident's comprehensive assessment.						
	Set assessment, date resident had a (BIMS) Status score 14, which cognitively intact. The important for the residence favorite activities, go of the second	ession (MDS) Minimum and 4/14/15, indicated the Brief Interview for Me the indicated the resident amount and make the MDS indicated it was dent to listen to music, coutside to get fresh air d, and to participate in practices.	e ntal t very do				
	resident had a BIMS	ated 10/18/15, indicate of 15, which indicated t ttact. The MDS indicate	he				

F 248 Continued From page 23 resident required limited staff assistance with walking in room, corridor, and extensive staff assistance with locomotion on the unit.  The 10/21/15 care plan instructed staff to assist		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
GREELEY COUNTY HOSPITAL LTCU  506 3RD ST PO BOX 338 TRIBUNE, KS 67879   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 248  Continued From page 23 resident required limited staff assistance with walking in room, corridor, and extensive staff assistance with locomotion on the unit.  The 10/21/15 care plan instructed staff to assist			17E071		B. WING		12/09	9/2015
TRIBUNE, KS 67879  (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 248 Continued From page 23 resident required limited staff assistance with walking in room, corridor, and extensive staff assistance with locomotion on the unit.  The 10/21/15 care plan instructed staff to assist	NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 248  Continued From page 23  resident required limited staff assistance with walking in room, corridor, and extensive staff assistance with locomotion on the unit.  The 10/21/15 care plan instructed staff to assist	GREELEY	COUNTY HOSPITAL	LTCU					
resident required limited staff assistance with walking in room, corridor, and extensive staff assistance with locomotion on the unit.  The 10/21/15 care plan instructed staff to assist	PREFIX	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL REG	II.	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETION
the resident as needed. The care plan instructed the activity director to invite and encourage the resident to attend activities the resident liked.  The activity attendance sheet revealed the following:  In September the resident did not attend any type of activity on 18 days during the month.  In October the resident did not attend an type of activity on 17 days during the month.  On 12/1/15 at 8:50 AM, observation revealed the resident did not attend or participate in an activity, during the first two days of the onsite survey.  On 12/2/15 at 8:45 AM, Nurse Aide I stated when the activity director is not in the facility, staff are to volunteer to do activities, if they have time, or volunteers from outside the facility will provide some activities.  On 12/2/15 at 8:50 AM, observation revealed a dry erase board between the guest bathroom and the drinking fountains stated activities for the day were nail care at 9:00 AM, exercises at 10:30 AM, cotton ball game at 3:00 PM, and bible study at 6:30 PM. Further observation revealed at 9:16 AM nail care was not provided by the facility. Continued observation revealed at 1:16 AM nail care was not provided by the facility. Continued observation revealed at 1:16 AM nail care and exercise activities started at the same time and the resident was present, but did not receive nail care.	F 248	resident required limit walking in room, corri assistance with locom. The 10/21/15 care plathe resident as needed the activity director to resident to attend activity attendance following:  In September the resident activity on 18 days. In October the resident activity on 17 days due. On 12/1/15 at 8:50 Al resident did not attend during the first two days. On 12/2/15 at 8:45 Al the activity director is volunteer to do activity volunteers from outside some activities.  On 12/2/15 at 8:50 Al dry erase board between the drinking fountains were nail care at 9:00 cotton ball game at 3:6:30 PM. Further observation care and exercise act time and the resident.	ted staff assistance with idor, and extensive staff notion on the unit.  an instructed staff to assed. The care plan instruct invite and encourage to invite and encourage to invite the resident liked ce sheet revealed the ident did not attend any of during the month.  My observation revealed or participate in an act any of the onsite survey.  My Nurse Aide I stated of the identification in the facility, staff ties, if they have time, of the determinance of the guest bathroom is stated activities for the of AM, exercises at 10:30 cm. AM, and bible study ervation revealed at 9:10 provided by the facility in revealed at 10:30 AM tivities started at the sale	sist cted che d	F 248			

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E071		B. WING		12/09/		
	OVIDER OR SUPPLIER  COUNTY HOSPITAL	LTCU	506 3RI	RESS, CITY, STA DIST PO BO IE, KS 6787	X 338			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AID DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 248	On 12/2/15 at 2:44 Pf when he/she is not in volunteers from outsid activities for the residuattend.  On 12/2/15 at 4:16 Pf resident likes to go to books. Nurse Aide F s remembers times of a assistance to activitie.  On 12/3/15 at 1:45 Pf stated staff should do resident. Administrativesident's spouse and resident daily.  The facility's 7/20/15 stated the facility ensuactivities for the residuaccommodate the indiand help enhance help sychosocial well-beic comprehensive assess.	M, Activity Staff C state the facility, a nurse aid de the facility provide the ent if he/she wants to the facility provide the ent if he/she wants to the facility provide the ent if he/she wants to the facility of the fac	the read ally r e A h the ed the olicy am of ests and r	F 248				
	- Resident #28's physician order sheet, dated 9/30/15, indicated the resident had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) and psychosis (any major mental disorder characterized by a gross impairment in reality							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
	17E071 B. WING 12/09/2 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		9/2015					
	OVIDER OR SUPPLIER	LTCLI						
GREELEY	COUNTY HOSPITAL	LICU		ST PO BO E, KS 6787				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	awake that appear to created).  The admission (MDS) assessment, dated 3/had a (BIMS) Brief Interpretation of the score 0. The MDS indextensive assistance transfer, dressing, and locomotion on and off for mobility. The MDS important for the reside things with groups of fresh air when the we important to do his/her the side of the	ations (sensing things we be real, but the mind be resident required for a staff for bed mobilid toilet use, supervision of unit, and used a whee indicated it was somewhent to listen to music, the people, go outside to greather is good, and very a favorite activity. In instructed staff to resident to attend an aconstructed staff to visit 1 the family visited sever of the care plan reveal repetitions related to are record indicated the invities 4 times in Septem y activities in October.  My Nurse Aide H stated ropelled him/herself to	sident us uired ity, n with elchair what to do et  ctivity, al led as  mber  the	F 248				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		17E071		B. WING		12/	09/2015	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
GREELEY	COUNTY HOSPITAL	LTCU		O ST PO BO NE, KS 6787				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 248	looking into the residents past occupation.  On 12/3/15 at 1:45 PM, Administrative Nurse A stated staff should do more 1:1 activities with the resident. Administrative Nurse A further stated the resident's spouse and family visit with the resident daily.  The facility's 7/20/15 Activity Assessments policy stated the facility ensured an ongoing program of activities for the resident, designed to accommodate the individual resident's interests and help enhance her/his physical, mental and psychosocial well-being, according to his/her comprehensive assessment.  The facility failed to offer, remind, and assist Resident #28, to attend activities, and provide activities in accordance with the resident's comprehensive assessment.		F 248					
	- Resident #14's annual (MDS) Minimum Data Set assessment, dated 10/4/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 0 which indicated severely impaired cognition. The assessment revealed the resident was dependent upon 2 staff for bed mobility, transfers, personal hygiene and bathing and 1 staff member for mobility on and off the unit, dressing and eating. The assessment further revealed it was somewhat important to the resident to listen to music, be around animals, keep up with the news, go outside, and participate in religious services. The resident's							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER		17E071		B. WING		12/09	)/2015
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
	COUNTY HOSPITAL	LTCU	506 3RI	ST PO BO	X 338		
			TRIBUN	IE, KS 6787	9		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	IATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 248	Continued From page 27			F 248			
	family or significant other completed the identification of activity preferences for the resident.  The 10/04/15 psychosocial well-being (CAA) Care						
	Area Assessment stated the resident does attend some activities each week, does not usually participate, but does like to watch. The CAA futher stated the resident does well when family and spouse visit.						
	The 10/14/15 care plan stated the resident would like to attend activities at least three times weekly and directed staff to invite him/her to devotions, church and reading programs. The care plan directed staff to offer to take the resident out to the courtyard on nice days and take him/her to nail care and hair care weekly. The care plan indicated the activity director will visit with the resident 1:1, 1-2 times monthly, and staff will provide 1:1 daily.						
	The September 2015 Activity Participation log revealed the resident attended 10 activities for the month. The log had no documentation of 1:1 visits with the activity director or staff, for the month of September.		or f 1:1				
	The October 2015 Activity Participation log revealed the resident attended 18 activities for the month. The log had no documentation of 1:1 visits with the activity director or staff, for the month of October.						
	The November 2015 Activity Participation log revealed the resident attended 4 activities for the month. The log had no documentation of 1:1 visits with the activity director or staff, for the month of November.		r the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E071 B. WING 12/09/20  R OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		9/2015				
	OVIDER OR SUPPLIER	LTOU						
GREELEY	COUNTY HOSPITAL	LICU		ST PO BO E, KS 6787				
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F 248	On 12/1/15 at 1:22 Pt resident resting in his observation revealed rest in bed at 2:06 Pt. On 12/2/15 at 4:00 Pt resident resting in his was not any music platelevision was not on revealed staff and rest Christmas tree and the activity.  On 12/3/15 at 9:07 At resident resting in bed devotion activity, with On 12/2/15 at 1:00 Pt resident doesn't really staff do 1:1 visiting with the company of	M, observation revealed the resident continued and at 3:45 PM.  M, observation revealed ther room in bed. Ther aying in the room and the Further observation sidents decorating the peresident did not attend the resident did not attend a singing, in the dining rows.  M, Nurse Aide D stated and do much for activities, with him/her.  M, Activity Staff C state puch for activities, and so observe group activities and as much 1:1 with him and a much 1:1 with him and a singing in the dining rows.  AM, Administrative Nurse aloes not attend many able to state any activities and as much 1:1 with him and a family meals every other ctivity Policy stated the ctivity Policy	d the de he he de he	F 248				
	activities designed to	accommodate the indiv	vidual					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E071		B. WING		12/09	9/2015	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•		
GREELEY	COUNTY HOSPITAL	LTCU		O ST PO BO IE, KS 6787				
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F 248	resident's interests to mental, and physical his/her comprehensiv  The facility failed to p of activities designed the physical, mental,	help his/her physical, well-being according to	ıram nd	F 248				
	for Resident #14.  483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE		8	F 274				
	A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)							
	This Requirement is not met as evidenced by: The facility had a census of 28 residents. The sample included 13 residents. Based on observation, record review and interview the facility failed to conduct a significant change assessment for 2 of the 13 sampled residents. (#10, #32)		e					
	Set assessment, date	rterly (MDS) Minimum I ed 7/12/15, indicated the ) Brief Interview for Mel	e					

INME OF PROVIDER OR SUPPLIER  GREELEY COUNTY HOSPITAL LTCU  SIRRETADDRESS, CITY, STATE, 2P CODE 508 3RD ST PD BOX 333  TRIBUNE, KS 67879  PROVIDERS PLAN OF CORRECTION TAGAINMARY STATEMENT OF DEFICIENCISS  PRETIX TAGA  CACH DEFICIENCY WINTER PROCEDED FOR CONTROLL OR LSC IDENTIFY IND INFORMATION  F 274  Continued From page 30  Status score of 7, which indicated severely impaired cognition and was independent with (ADLs) Activities of Daily Living.  Resident #10's quarterly MDS, dated 10/11/15, indicated the resident had a BIMS of 8, which indicated the resident and a BIMS of 8, which indicated the resident proper limited staff assistance with ADLs except, supervision with eating.  The 10/14/15 care plan indicated the resident required staff assistance with ambulating, with his/her four wheeled walker.  On 12/2/15 at 4:16 PM, Nurse Aide F stated the resident required staff assistance with ADLs.  On 12/2/15 at 10:38 AM, Administrative Nurse verified the resident required staff assistance with ADLs.  On 12/3/15 at 10:38 AM, Administrative Nurse verified the resident required resident required the resident required the resident required the resident required the resident requ	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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FREFIX TAG  GRACH DEPICIENCY MUST BE PRECEDED BY FULL RESULATORY TAG  OR LSC DENTIFYING INFORMATION)  F 274  Continued From page 30  Status score of 7, which indicated severely impaired cognition and was independent with (ADLs) Activities of Daily Living.  Resident #10's quarterly MDS, dated 10/11/15, indicated the resident paired dignited staff assistance with ADLs except, supervision with eating.  The 10/14/15 care plan indicated the resident required staff assistance with ambulating, with his/her four wheeled walker.  On 12/1/15 at 9:00 AM, observation revealed staff assistance with assistance with ADLs.  On 12/2/15 at 4:16 PM, Nurse Aide F stated the resident required staff assistance with ADLs.  On 12/2/15 at 2:40 PM, Nurse Aide F stated the resident required staff assistance with ADLs.  On 12/3/15 at 10:38 AM, Administrative Nurse verified the resident had changes in several areas of ADLs from 7/12/15 quarterly MDS to 10/11/15  quarterly MDS and stated there should have been a significant change MDS on 10/11/15.  The Resident Assessment Instrument Manual Version 3.0 defines a significant change as a				TRIBUN	NE, KS 6787	9		
Status score of 7, which indicated severely impaired cognition and was independent with (ADLs) Activities of Daily Living.  Resident #10's quarterly MDS, dated 10/11/15, indicated the resident had a BIMS of 8, which indicated moderately impaired cognition. The MDS indicated the resident required limited staff assistance with ADLs except, supervision with eating.  The 10/14/15 care plan indicated the resident was able to transfer him/herself from his /her wheelchair to the recliner, to the toilet, and back. The care plan indicated the resident required staff assistance with ambulating, with his/her four wheeled walker.  On 12/1/15 at 9:00 AM, observation revealed staff assisting the resident with a gait belt and four wheeled walker from his/her room to the dining room.  On 12/2/15 at 4:16 PM, Nurse Aide F stated the resident required staff assistance with ADLs.  On 12/2/15 at 2:40 PM, Nurse B stated the resident required staff assistance with ADLs.  On 12/3/15 at 10:38 AM, Administrative Nurse verified the resident had changes in several areas of ADLs from 71/12/15 quarterly MDS to 10/11/15 quarterly MDS and stated there should have been a significant change MDS on 10/11/15.  The Resident Assessment Instrument Manual Version 3.0 defines a significant change as a	PRÉFIX	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL REG	GULATORY	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETION
*Will not normally resolve itself without	F 274	Status score of 7, whi impaired cognition and (ADLs) Activities of D. Resident #10's quarter indicated the resident indicated moderately MDS indicated the resassistance with ADLs eating.  The 10/14/15 care plasmas able to transfer his wheelchair to the recl. The care plan indicate assistance with ambus wheeled walker.  On 12/1/15 at 9:00 All assisting the resident wheeled walker from room.  On 12/2/15 at 4:16 Plasmas in the resident required staff.  On 12/2/15 at 10:38 A verified the resident hof ADLs from 7/12/15 quarterly MDS and stars a significant change of the resident of ADLs from 3.0 defines a decline or improvement.	ich indicated severely d was independent with aily Living.  erly MDS, dated 10/11/2 had a BIMS of 8, which impaired cognition. The sident required limited sexcept, supervision with an indicated the resident im/herself from his /her iner, to the toilet, and be edited the resident required liating, with his/her four M, observation revealed with a gait belt and four his/her room to the dinition.  M, Nurse Aide F stated from the fassistance with ADLs.  M, Nurse B stated the from the fassistance with ADLs.  AM, Administrative Nurse and changes in several quarterly MDS to 10/12 ated there should have MDS on 10/11/15.  The ment Instrument Manual significant change as a sent in a resident's status.	15, h estaff th ack. d staff or ng the areas 1/15 been	F 274			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
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F 274	disease-related clinica "self-limiting" (for deci- *Impacts more than 1 health status: and *Requires interdiscipl of the care plan.	r by implementing standal interventions, is not line only) area of the resident's inary review and/or review and/or review and/or standar care of Resident #10,	ision	F 274				
	- Resident #32's admission (MDS) Minimum Data Set assessment, dated 8/17/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 14, which indicated intact cognition. The assessment revealed the resident required limited assistance of 1 staff member for bed mobility, dressing, toileting, personal hygiene, transfers, ambulation in room, and supervision of 1 staff member for ambulation in corridor, locomotion on and off the unit. The resident required supervision and set up assistance with eating.		ntact dent r for giene, on of					
	resident had long and problems with severe skills. The assessmer required extensive as for bed mobility, trans unit, dressing, toileting extensive assistance	ated 11/17/15, indicate I short term memory ly impaired decision mant revealed the resident sistance of 2 staff memores, locomotion on and g, personal hygiene, arof one staff member for the forther revealed the	aking : nbers d off nd					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF PR	ME OF PROVIDER OR SUPPLIER STREET			ESS, CITY, STA	TE, ZIP CODE		
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F 274	Continued From page 32 resident ambulated 1 time in his/her room and no ambulation in the corridor.  On 12/1/15 at 11:58 AM, observation revealed the			F 274			
	On 12/1/15 at 11:58 AM, observation revealed the resident lying in bed with his/her eyes closed.  On 12/2/15 at 8:00 AM, observation revealed Nurse Aide F elevated the resident's head of his/her bed, asked the resident if he/she was hungry. The resident whispered "No". Nurse Aide F placed a toothette and into a glass of water to give to the resident. The resident did accept the toothette multiple times but did not want to eat or drink anything else. Continued observation revealed Nurse Aide F and Nurse Aide D put the head of the bed down and rolled the resident onto his/her left side. Nurse Aide F performed personal hygiene care on the resident and replaced the disposable incontinent chucks pad under the resident, placed a pillow between his/her legs, and covered the resident.		d.  d f s e Aide er to the eat or t the t onto rsonal ne				
	On 12/2/15 at 4:16 PM, observation revealed Nurse Aide G and Nurse Aide D rolled the resident to his/her right side,and performed personal hygiene on the resident. Further observation revealed the resident stated he/she wanted to get up and sit on the toilet. Nurse Aide D and Nurse Aide G started to sit the resident on the edge of the bed, the resident closed his/her eyes and leaned over resting his/her head onto Nurse Aide G. Continued observation revealed Nurse Aide D left the room to get the nurse to assess the resident.		she Aide nt on her nto				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 274	Continued From page 33 On 12/3/15 at 1:47 PM, observation revealed the resident lying in bed with his/her eyes closed.  On 12/2/15 at 8:00 AM, Nurse Aide F stated the resident was unable to tolerate leaving his/her room due to his/her decline.  On 12/2/15 at 4:16 PM, Nurse Aide G stated the resident does not eat well for staff or family and had become weak. Nurse Aide G further stated the resident does not leave his/her room anymore and was dependent upon the staff for all activities of daily living.  On 12/3/15 at 1:45 PM, Administrative Nurse A stated the staff should have completed a significant change for the resident since he/she had a significant decline.  The Resident Assessment Instrument Manual 3.0 defines a significant change as a decline or improvement in a resident's status that:		the and ted whore vities	F 274		OT TAKE		
	intervention by staff or by implementing standard disease related clinical interventions, is not "self-limiting" (for decline only) -Impacts more than 1 area of the resident's health status: and -requires interdisciplinary review and/or revision of the care plan.							
	The facility failed to co MDS for Resident #32 decline.	onduct a significant cha 2, who had an overall	ange					
F 278	483.20(g) - (j) ASSES	SSMENT		F 278				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` ,	(X3) DATE SURVEY COMPLETED		
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F 278	Continued From page ACCURACY/COORD The assessment must resident's status.  A registered nurse must each assessment with participation of health A registered nurse must see assessment is completed assessment is completed. Each individual who cassessment must significant portion of the assessment must significant portion of the assessment in a resubject to a civil mone \$1,000 for each asses willfully and knowingly to certify a material air resident assessment penalty of not more thassessment.  Clinical disagreement material and false statement is The facility had a censample included 13 reobservation, record resident, record resi	e 34 DINATION/CERTIFIED It accurately reflect the Just conduct or coordina In the appropriate In professionals.  Just sign and certify that Just sign and certify that Just sign and certify that Just sign and certify the Just sign and certify the Just sign and certify that Just sign and certify the Just sign and certify the Just sign and certify the Just sign and certify that Just sign and certify	the he acy of who d than il who dual hey	F 278					
		ately assess resident st m Data Set assessmer lents. (#14, #32)							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
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F 278	Continued From page	e 35		F 278				
	Set assessment, dateresident had long and problems with severe skills. The assessment required extensive as for bed mobility, transpersonal hygiene and The assessment furth had a weight loss and prescribed weight loss. The care plan, dated would maintain adequive maintaining his/her with was on a pureed diet. staff to give the resident vanimultivitamin supplement. On 12/2/15 at 8:00 Al Nurse Aide F and Nur of the resident's bed to breakfast. Further obs. Aide F offered the resident refused.  On 12/2/15 at 8:10 Al resident did not eat wishake and ensure with staff and staff and ensure with staff and staff and ensure with staff and ensure	ly impaired decision mant revealed the resident sistance of 2 staff members, dressing, toileting and the revealed the resident was on a physician is regimen.  11/19/15, stated the resulte nutritional status, beight within 2 pounds, and The care plan directed ent power shakes, three acket of benecalorie (and time a day, for weight and sorder directed staffilla yogurt with meals, and the state acket of benecalorie (and time and the resident with the state acket of benecalorie).  My observation revealed staffilla yogurt with meals, and the state acket of benecalorie (and the state acket of benecalorie).  My observation revealed the final state of the	he aking hobers hobers high loss. If to and a dead high loss high					

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA		1 ' '	LE CONSTRUCTION	, ,	(X3) DATE SURVEY	
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F 278	Continued From page 36			F 278				
	On 12/3/15 at 1:45 PM, Administrative Nurse A stated the resident had a significant weight loss, was not on a physician planned weight loss regimen, and verified the MDS was inaccurate.  The Resident Assessment Instrument, user							
	The Resident Assessment Instrument, user manual version 3.0, stated the definition of a physician prescribed weight-loss regimen is a weight reduction plan ordered by the resident's physician with the care plan goal of weight reduction. The physician may employ a calorie-restricted diet or other weight loss diets and exercise. This would also include planned diuresis (increased or excessive production of urine) and it is important that weight loss is intentional.							
	The facility failed to accurately document, no planned weight loss management on the MDS, for Resident #32, who had a significant weight loss.  Resident #14's quarterly (MDS) Minimum Data Set assessment, dated 7/8/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 0 which indicated severely impaired cognition. The assessment revealed the resident was dependent upon 2 staff for bed mobility, transfers, mobility on the unit, eating, toilet use, dressing, personal hygiene, bathing, and 1 staff member for mobility off the unit. The assessment further revealed the resident walked in his/her room once or twice, during the assessment period with one staff assist, and walked in the corridor once or twice during the assessment period with 2 staff assist.  Resident #14's annual MDS assessment, dated							
	10/4/15, indicated the of 0 which indicated s	e resident had a BIMS severely impaired cognitional the resident was	core					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 278 Continued From page dependent upon 2 start dressing, personal hyg staff member for mobil use, and eating. The athe resident walked in during the assessment assist, and walked in the during the assessment.  The 10/4/15 (CAA) Car (ADL) Activities of Dail Functional/Rehabilitati.  The care plan, dated 7 the resident was unab weakness and Alzheim plan further stated the for mobility, unable to directed the staff to us mechanical lift that allow transferred from one so the resident having to assist for all transfers.  On 12/2/15 at 8:57 AM Nurse Aide D and Nurse Aide D and Nurse sident with the Hoye into his/her bed, province cares, and repositione.  On 12/3/15 at 2:56 PM stated the resident had verified that the reside Administrative Nurse Aide Coding was inaccurate.  The (RAI) Resident Assigned and the resident coded on the area of the resident code of the resident code of t	off for bed mobility, transplene and bathing; and gliene and bathing; and gliene and bathing; and gliene and off the unit, assessment further revents of the corridor once or twith the twinting on Potential did not triple of the the angle of the corresponding	toilet ealed twice ice sist.  or gger. stated to e lchair and  out aff  d he eair ce e A and walk. DS	F 278			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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F 278 F 280 SS=D	self-performance if the than three times. The 4, pages 2-10, CAA dexplain the basis for how the interdisciplin underlying causes, of factors that were relaced condition for a specific The facility failed to a Resident #14's quart Section G and on the 483.20(d)(3), 483.10 PARTICIPATE PLAN  The resident has the incompetent or other incapacitated under the section of	ne activity occurred fewer RAI also stated in char documentation helps to the care plan by showing the care area area fic resident.  Caccurately assess and caterly and annual MDS in the cannual MDS.  Calcillation (k)(2) RIGHT TO INING CARE-REVISE Cateright, unless adjudged the rouge found to be the laws of the State, to ag care and treatment or	pter ng ne risk ode	F 278	DETIGENOT)				
	within 7 days after the comprehensive asses interdisciplinary teams physician, a registere for the resident, and disciplines as determent, to the extent professional to the extent professional revised by a team each assessment.  This Requirement is	essment; prepared by arm, that includes the attered nurse with responsible other appropriate staff in inned by the resident's nacticable, the participation dent's family or the resident's family or the resident's family or the resident's family or the resident periodically review mof qualified persons a second not met as evidenced the subsection of the second periodically review mof qualified persons a second periodically review mof qualified persons a second periodically review mof qualified persons a second periodically review most period	n nding ility n leeds, on of dent's ed after						

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, ,		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E071		B. WING	<del></del>	12/09/2015	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	•	
GREELEY	COUNTY HOSPITAL	LTCU	506 3RD	ST PO BO	X 338		
			TRIBUN	E, KS 6787	9		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 280	Continued From pag	e 39		F 280			
	observation, record re	eview and interview, the	e				
	facility failed to review	v and revise the care pl	an for				
	1 sampled resident for	or accidents. (#32)					
	Findings included:						
	- Resident #32's adm	nission (MDS) Minimum	,				
		t, dated 8/17/15, indicat	I				
		IMS) Brief Interview for	I				
	Mental Status score	of 14. The assessment					
	revealed the resident	required limited assista	ance				
		bed mobility, transfers,					
		d personal hygiene. Th					
		evealed the resident ha	-				
	impairment, and no fa	o functional upper or lov alls since admission.	ver				
	•	are Area Assessment fo	or				
		lated 11/17/15, indicate	d the				
	resident had long and						
		ly impaired cognition. T	he				
		the resident required of 3 staff for bed mobil	ity				
	transfers, toileting, dr		ity,				
		ment further revealed the	ne				
		y balance, no functiona	I				
		ment, and had 2 or mo	I				
	falls since admission.						
	The 8/13/15 care plan stated the resident, a high		high				
	•		-				
	risk for falls, had an unsteady gait, and used the call light when needing assistance. The care plan						
	•	eep the bed in the lowe					
		njury should he/she fall					
	of bed. The updated 11/6/15 care plan directed						
		at beside the resident's					
		further intervention for	I				
	after the resident had	l falls on 11/12/15, 11/1	8/15,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		17E071		B. WING		12/0	12/09/2015	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
GREELEY	COUNTY HOSPITAL	LTCU		D ST PO BO NE, KS 6787				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 280	the staff found the reselbows on the floor, a The note further indiche/she was trying to so note stated the staff a his/her feet, and then bathroom. The note filegs gave out while be and the staff used a verback to bed.  The 11/12/15 at 6:45 staff found the resident his/her recliner on his stated the resident's at the chair and stated to the facility educated alarm was appropriated. The 11/18/15 at 1:35 staff found the resident floor mat and his/her note stated the resident abrasions to the top at The 11/18/15 fall risk resident was a high risk resident was a high risk resident was a high risk resident was the resident staff found his/her resident had no injury	d 12/3/15.  M, nurse's note indicate sident on his/her knees few feet from his/her bated the resident stated shut off his/her light. The assisted the resident to assisted him/her to the urther stated the reside eing assisted back to be wheelchair to get him/her.  PM, nurse's note stated the reside eing assisted back to be wheelchair to get him/her.  PM, nurse's note stated the resident on the floor in front of wher alarm pad. The note alarm was not connected the resident had no injust the staff to make sure the ely attached.  AM, nurse's note stated and front of his/her head on legs still in the bed. The end front of his/her head assessment indicated the sk for falls.  PM, nurse's note stated the standing beside his/hersknees. The note stated the st	and ed. d e e e e nt's ed f te d the f te d the d the e d the e d the he d the	F 280				
	resident leaned over	PM, nurse's note stated the armrest of the reclir ould not get the residen	ner					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		17E071		B. WING		12/0	9/2015	
	OVIDER OR SUPPLIER			ESS, CITY, STA				
GREELEY COUNTY HOSPITAL LTCU				ST PO BO E, KS 6787				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULA OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 280	back up into the recline resident's spouse ass footrest of the recline.  The 12/3/15 at 6:14 A staff found the reside on the floor mat beside the alarm was sounding assisted back to bed.  On 12/1/15 at 11:58 A resident lying in his/her Further observation roup and leaning agains on the floor, as outline.  On 12/2/15 at 8:00 Al resident has a lot of faget up on his/her own the resident has a pebeside his/her bed.  On 12/2/15 at 2:40 Pl the resident has a peadmission and the fall after a fall. Licensed I staff frequently check.  On 12/3/15 at 1:45 Pl stated the staff frequently check.  On 12/3/15 at 1:45 Pl stated the staff frequently check.  The 6/18/07 facility's facility would provide	ner. The note stated the sisted the resident down r and onto the floor.  M, nurse's note stated nt lying on his/her right le the bed. The note stang and the resident was a management of the bed are bed with eyes closed evealed the fall mat folds the end of the bed are do in the plan of care.  M, Nurse Aide F stated alls because he/she tries. Nurse Aide F further streonal alarm and a fall of the mat was a new interventions and the resident.  M, Licensed Nurse B streonal alarm since I mat was a new interventions and the resident.  M, Administrative Nurse ently check the resident essure pad alarm.  A stated the nurse show re with interventions after the couract of the couract	the side ated s ed the did not the es to stated mat ated ention he e A and ald er a lithe ts to	F 280				

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, ,		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SU COMPLE			
		17E071		B. WING	<del></del>	12/0	09/2015		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	· •			
GREELEY	COUNTY HOSPITAL	LTCU		BRD ST PO BOX 338 UNE, KS 67879					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 280	to develop, review an plan. The policy furth corrections and chan resident's care plan beneeded, between car.  The facility failed to re-	sing the resident assess and revise the resident's er stated the care planges would be made to be editing the care plan, re plan meetings.  eview and revise the canterventions, for Reside	care the as	F 280					
	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.		F 281						
	The facility had a censample included 13 mobservations, record facility failed to meet quality care for not for 1 of the 13 sampled modern frindings included:  - Resident #19's diagonder Sheet, dated 1 The quarterly (MDS) assessment, dated 1 resident had a (BIMS)	review and interview, the professional standard of allowing physician's orderesidents. (#19)  Inoses from the Physician's included weight Minimum Data Set 0/25/15, indicated the self-brief interview for Me	e ne of ers for an's : loss.						
	cognitive impairment the resident had a we 30 days, or 10% or m	ich indicated moderate. The assessment revea eight loss of 5% or more nore in 180 days.	aled e in						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
GREELEY	COUNTY HOSPITAL	LTCU		O ST PO BO NE, KS 6787				
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F 281	own meal choices, and Review of the medica 8/27/15, a Doctor Corfaxed to the physician recommended considering mineral supplement, on physician agreed with Further review of the physician's order, for minerals, was not initial. Review of the Septem (MAR) Medication Addrevealed no document administered to the resident seated in his room, at a table set for meet his/her needs.  On 12/2/15 at 12:15 For staff served the lunch resident, who was sea a table. Further obserthe resident a supplement a supplement).  On 12/2/15 at 2:55 Physician's order for resupplement was starthad not received the interest of the resident of the resident of the supplement was starthad not received the interest of the resident of the supplement was starthad not received the interest of the supplement was starthad not received the interest of the supplement was starthad not received the supplement was starthad no	es/allergies, makes his/ad has a diet as tolerate and has a diet as tolerate all record revealed on a stating the Dietitian lering a multi-vitamin with a the recommendations. The ather ecommendations a multi-vitamin with lated for the resident.  The recommendations a multi-vitamin with lated for the resident.  The recommendations a multi-vitamin with lated for the resident.  The roctober/Novembe ministration Record attation of a multivitamin esident.  The wheelchair in the dower than standard heigh and were the staff sement containing Coke a cordered dietary.  The resident and the resident with miner ed, and verified the resident.  The recommendations are the multi-vitamin with miner ed, and verified the resident and containing policy indicate and containing policy indicate.	ed.  ith  ith  id the  r  ed the  lining  jht to  ed  air at  erved  and  e A  al  ident	F 281				
		nmunication sheet to the returned to the facility v						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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GREELEY COUNTY HOSPITAL LTCU				D ST PO BO NE, KS 6787				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 281	Continued From page	e 44		F 281				
	orders, the communication sheet should be noted by a nurse, and orders taken off by the nurse.							
	The facility failed to provide professional standard of care by not initiating the physician ordered multi-vitamin with minerals supplement for weight loss to Resident #19.		t l					
	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS			F 312				
	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.		:0					
	This Requirement is not met as evidenced by: The facility had a census of 28 residents. The sample included 13 residents. Based on observation, record review and interview, the facility failed to provide the necessary services to maintain grooming and personal hygiene for 1 of the 3 residents reviewed for activities of daily living. (#32)							
	Findings included:							
	Data Set assessment the resident had a (BI Mental Status score of revealed the resident of 1 staff member for toileting. The assessment	nission (MDS) Minimum i, dated 8/17/15, indicat IMS) Brief Interview for of 14. The assessment required limited assista bed mobility, transfers, ment further revealed th pon 1 staff member for	ance and					
	The 8/17/15 (CAA) Cactivities of daily living	are Area Assessment fo g was not completed.	or					

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			1 ' '		(X3) DATE SURVEY COMPLETED
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OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	
COUNTY HOSPITAL	LTCU				
		TRIBUN	E, KS 6787	9	
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGU OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	LD BE COMPLETION
Continued From page 45			F 312		
The quarterly MDS, oresident had long and problems with severe assessment revealed extensive assistance transfers, toileting, dr. hygiene. The assessibathing did not occur period.  The 11/19/15 care play preferred showers and the resident with a sh. The September 2015 resident hospitalized only received a show 9/30/15.  The October and Novindicated the resident showers for both more On 12/3/15 at 9:30 Airesident lying in bed of Further observation mand face appeared cl. On 12/3/15 at 9:51 Airesident offer the resident resident of the refuses On 12/3/15 at 1:45 Pl stated the resident should have and verified the docu	dated 11/17/15, indicated short term memory by impaired cognition. To the resident required of 3 for bed mobility, ressing and personal ment further revealed during the assessment an indicated the resident did directed the staff to an ower 2 times a week. To bathing record revealed from 9/1/15-9/18/15 and the received a total of 8 meths.  My observation revealed with his/her eyes closed evealed the resident's hean.  My Nurse Aide E stated at a bath daily but the second of the staff to a council to a council to the staff to a council to a council to the staff to a council to a council to the staff to a council to a council to a council to the staff to a council	of the sin the			
the resident refused a	a bath he/she still exped				
	COUNTY HOSPITAL  SUMMARY S (EACH DEFICIENCY MUSOR LSC ID  Continued From page  The quarterly MDS, or resident had long and problems with severe assessment revealed extensive assistance transfers, toileting, dringlene. The assess bathing did not occur period.  The 11/19/15 care play preferred showers and the resident with a shad the resident with a shad the resident hospitalized only received a show 9/30/15.  The October and Novindicated the resident showers for both more on 12/3/15 at 9:30 A resident lying in bed of Further observation in and face appeared of the staff should have resident often refuses on 12/3/15 at 1:45 P stated the resident should have and verified the docu 2 months. Administration the resident refused at the resident re	OVIDER OR SUPPLIER COUNTY HOSPITAL LTCU  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REOR LSC IDENTIFYING INFORMATION)  Continued From page 45  The quarterly MDS, dated 11/17/15, indicate resident had long and short term memory problems with severely impaired cognition. The assessment revealed the resident required extensive assistance of 3 for bed mobility, transfers, toileting, dressing and personal hygiene. The assessment further revealed bathing did not occur during the assessment period.  The 11/19/15 care plan indicated the resident preferred showers and directed the staff to a the resident with a shower 2 times a week.  The September 2015 bathing record revealer resident hospitalized from 9/1/15-9/18/15 and only received a shower 2 times from 9/18/15 9/30/15.  The October and November 2015 bathing reindicated the resident received a total of 8 showers for both months.  On 12/3/15 at 9:30 AM, observation revealed resident lying in bed with his/her eyes closed Further observation revealed the resident's had face appeared clean.  On 12/3/15 at 9:51 AM, Nurse Aide E stated staff offer the resident a bath daily but the resident offer refuses.  On 12/3/15 at 1:45 PM, Administrative Nurse stated the resident should have had more be or the staff should have documented correct and verified the documentation of only 8 batic 2 months. Administrative Nurse A further sta	TOURTHORNIA STREET ADDRESTRIBUNG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 45  The quarterly MDS, dated 11/17/15, indicated the resident had long and short term memory problems with severely impaired cognition. The assessment revealed the resident required extensive assistance of 3 for bed mobility, transfers, toileting, dressing and personal hygiene. The assessment further revealed bathing did not occur during the assessment period.  The 11/19/15 care plan indicated the resident preferred showers and directed the staff to assist the resident with a shower 2 times a week.  The September 2015 bathing record revealed the resident hospitalized from 9/1/15-9/18/15 and only received a shower 2 times from 9/18/15 - 9/30/15.  The October and November 2015 bathing record indicated the resident received a total of 8 showers for both months.  On 12/3/15 at 9:30 AM, observation revealed the resident lying in bed with his/her eyes closed. Further observation revealed the resident's hair and face appeared clean.  On 12/3/15 at 9:51 AM, Nurse Aide E stated the staff offer the resident a bath daily but the resident often refuses.  On 12/3/15 at 1:45 PM, Administrative Nurse A stated the resident should have had more baths or the staff should have documented correctly and verified the documentation of only 8 baths in 2 months. Administrative Nurse A further stated if the resident refused a bath he/she still expected	OVIDER OR SUPPLIER  COUNTY HOSPITAL LTCU  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 45  The quarterly MDS, dated 11/17/15, indicated the resident had long and short term memory problems with severely impaired cognition. The assessment revealed the resident required extensive assistance of 3 for bed mobility, transfers, toileting, dressing and personal hygiene. The assessment further revealed bathing did not occur during the assessment period.  The 11/19/15 care plan indicated the resident preferred showers and directed the staff to assist the resident with a shower 2 times a week.  The September 2015 bathing record revealed the resident hospitalized from 9/1/15-9/18/15 and only received a shower 2 times from 9/18/15 - 9/30/15.  The October and November 2015 bathing record indicated the resident received a total of 8 showers for both months.  On 12/3/15 at 9:30 AM, observation revealed the resident lying in bed with his/her eyes closed. Further observation revealed the resident's hair and face appeared clean.  On 12/3/15 at 9:51 AM, Nurse Aide E stated the staff offer the resident a bath daily but the resident often refuses.  On 12/3/15 at 1:45 PM, Administrative Nurse A stated the resident should have had more baths or the staff should have documented correctly and verified the documentation of only 8 baths in 2 months. Administrative Nurse A further stated if the resident refused a bath he/she still expected	OVIDER OR SUPPLIER  COUNTY HOSPITAL LTCU  STREETADDRESS, CITY, STATE, ZIP CODE 508 3RD ST PO BOX 338  TRIBUNE, KS 67879  RECH DEFICIENCY MUST BE PRECIDED BY TULL RECULATORY TAG  CROSS REFERENCED TO THE APPRODEST POR STREET PROPERTY AND PROPERTY TO THE QUARTER STREET PROPERTY AND PROPERTY TO THE QUARTER STREET PROPERTY AND PROPERTY TO THE QUARTER STREET PROPERTY TO THE APPRODEST PROPERTY P

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NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
	COUNTY HOSPITAL	LTCU	506 3RI	D ST PO BO	X 338			
			TRIBU	NE, KS 6787	9			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 312	Continued From page	e 46		F 312				
	aide will make every all residents during the hours of Monday thro PM and the baths are computer system. The resident refused, the the resident continues Service Designee wo assistance.  The facility failed to e received a shower or		s to d ::00 cility's if the and if					
	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.			F 323				
	The facility had a cen sample included 13 re reviewed for accident record review and inte ensure that the reside	not met as evidenced be sus of 28 residents. The esidents of which 3 wer is. Based on observation erview the facility failed ents' environment remains azards as possible for 1 ls. (#32)	e re on, to ins					
	- Resident #32's adm	nission (MDS) Minimum t, dated 8/17/15, indicat						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ITE, ZIP CODE	•	
GREELEY COUNTY HOSPITAL LTCU		LTCU		ST PO BO E, KS 6787			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 323	the resident had a (B) Mental Status score or revealed the resident of 1 staff member for toileting, dressing, an assessment further reunsteady balance, no impairment, and no father than the staff to ke position to minimize in of bed. The updated staff to place a fall mather than the staff found the resident had 11/24/5, 11/28/15, and the staff found the resident had 11/24/5, and	MS) Brief Interview for of 14. The assessment required limited assistated mobility, transfers, d personal hygiene. The evealed the resident had functional upper or low alls since admission.  The area Assessment for was not completed.  The resident required area for bed mobility, essing, and personal ment further revealed they balance, no functional ment, and had 2 or more assistance. The care seep the bed in the lower highly should he/she fall 11/6/15 care plan direct at beside the resident's further intervention for falls on 11/12/15, 11/15	e d d ver or d the The high the plan st out ed bed. staff 8/15, ed and ed. d	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  GREELEY COUNTY HOSPITAL LTCU			506 3RD	ESS, CITY, STA ST PO BO E, KS 6787	X 338			
(X4) ID PREFIX TAG	ID SUMMARY STATEMENT OF DEFICIENCIES FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 323	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 323					

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GREELEY COUNTY HOSPITAL LTCU 506 38				DDRESS, CITY, STATE, ZIP CODE  RD ST PO BOX 338  UNE, KS 67879				
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F 323	assisted back to bed. On 12/1/15 at 11:58 Aresident lying in his/h Further observation rup and leaning again on the floor, as outlin. On 12/2/15 at 8:00 Alresident has a lot of figet up on his/her own the resident has a pebeside his/her bed. On 12/2/15 at 2:40 Plate the resident has a peadmission and the fall after a fall. Licensed staff frequently check on 12/3/15 at 1:45 Plate the staff frequently check on 12/3/15 at 1:45 Plate the resident has a preadministrative Nurse update the plan of cafall. The 7/12/13 facility's residents are considerage, diagnoses, med environment. The pol shall be completed to the staff assess the rekeep beds in low posculter, assistive deviron bed and chair alarm. The facility failed to in	AM, observation revealed er bed with eyes closed evealed the fall mat folds the end of the bed ared in the plan of care.  M, Nurse Aide F stated alls because he/she tried. Nurse Aide F further strength and a fall of the end of the	d. ded ded ded ded ded ded ded ded ded d	F 323				

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER			ESS, CITY, STA				
GREELEY	COUNTY HOSPITAL	. LTCU		ST PO BO E, KS 6787				
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F 323	Continued From pagmultiple falls.	је 50		F 323				
	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS			F 329				
	unnecessary drugs. drug when used in exduplicate therapy); of without adequate more indications for its use adverse consequences should be reduced or combinations of the resident, the facility rewho have not used a given these drugs untherapy is necessary as diagnosed and do record; and residents drugs receive gradual behavioral intervention.	nensive assessment of a must ensure that resider antipsychotic drugs are r nless antipsychotic drug to treat a specific condi- ocumented in the clinical s who use antipsychotic al dose reductions, and	s any control of the second of					
	The facility had a cer sample included 13 r reviewed for unneces observation, record r facility failed to adequate to a server of the facility failed to adequate the facility failed to adequ	f 5 residents reviewed for	e re ed on e					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
17E071			B. WING		12/09/2015			
	OVIDER OR SUPPLIER			RESS, CITY, STA				
GREELEY	COUNTY HOSPITAL	LTCU		O ST PO BO IE, KS 6787				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	CTION SHOULD BE CON THE APPROPRIATE		
F 329	Continued From page	e 51		F 329				
	- Resident #32's medical record revealed the facility admitted the resident on 8/11/15.  The (POS) physician's order sheet, dated 9/18/15, revealed the resident had a diagnosis of constipation (bowel movements that are infrequent or hard to pass).							
	The admission (MDS) Minimum Data Set assessment, dated 8/17/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 14. The assessment revealed the resident required limited assistance of 1 staff member for bed mobility, transfers, toileting, dressing, and personal hygiene. The assessment further revealed the resident was always continent of bowel.							
	The quarterly MDS, dated 11/17/15, indicated the resident had long and short term memory problems with severely impaired cognition. The assessment revealed the resident required extensive assistance of 3 for bed mobility, transfers, toileting, dressing, and personal hygiene. The assessment further revealed the resident was occasionally incontinent of bowel.							
	have constipation and the resident per the to	n stated the resident did d directed the staff to to bileting schedule. The c for the staff regarding b	oilet care					
	The 8/11/15 physician standing orders directed the staff to administer the following: (MOM) Milk of Magnesium, (a laxative for constipation) 30 (cc) cubic centimeters, by mouth, with breakfast, if no bowel movement for 3 days. Dulcolax Suppository, (a laxative for constipation							

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17E071			B. WING		12/09/2015			
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
GREELEY	COUNTY HOSPITAL	LTCU		ST PO BO E, KS 6787				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 329	OVIDER OR SUPPLIER  COUNTY HOSPITAL LTCU  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 329					
		and staff tell him/her w d a bowel movement af						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
17E0		17E071		B. WING		12/09/2015		
	OVIDER OR SUPPLIER  COUNTY HOSPITAL	LTCU	506 3R	RESS, CITY, STA D ST PO BO NE, KS 6787	X 338	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 329	·		F 329					
F 371	management progran	n, complete appropriate and follow the physicia owel management for	9	F 371				
	STORE/PREPARE/S  The facility must - (1) Procure food from considered satisfacto authorities; and	ERVE - SANITARY sources approved or ry by Federal, State or stribute and serve food		F 3/1				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
17E071			B. WING		12/09/2015			
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	I		
GREELEY	COUNTY HOSPITAL	LTCU		ST PO BO E, KS 6787				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 371	Continued From page 54			F 371				
	This Requirement is not met as evidenced by: The facility had a census 53 residents. The sample included 13 residents. Based on observation, record review, and interview the facility failed to prepare, distribute and serve food under sanitary conditions in 1 of 1 dining rooms.  Findings included:  On 12/2/15 at 11:50 AM, observation revealed the following food temperatures, taken from the lunch meal: pureed lasagna 135 degrees Fahrenheit and the pureed baked potatoes 122 degrees Fahrenheit.  Review of the food temperature logs, for the lunch meal on 12/2/15, revealed no documentation of the pureed foods.		food ms.					
	revealed during the m 10/8/15 and 10/9/15 trecorded for the breal 10/8/15, 10/9/15, 10/7 temperatures were no noon/lunch meal. On 10/9/15, 10/11/15, 10/10/22/15 temperature supper meal.  Further review of the revealed during the m 11/20/15 and 11/22/15 recorded for the breal	ot recorded for the 10/1/15, 10/2/15, 10/5/	15, r the ogs 5, on ot oon					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
17E071			B. WING		12/0	9/2015		
	OVIDER OR SUPPLIER			RESS, CITY, STA				
				O ST PO BO IE, KS 6787				
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F 371	11/16/15, 11/21/15, 11/29/15, and 11/3011 recorded for the supp On 12/2/15 at 4:00 PI he/she was aware of being recorded, on the and stated the dietary. The facility food temp 3/22/13, stated all tembe taken and properly. The food temperature stated all hot food item appropriate internal teserved at a temperature fahrenheit. Temperature periodically to ensure degrees Fahrenheit, adegrees Fahrenheit diransporting, and served by the resident.  The facility failed to pure food under sanitary of	1/22/15, 11/23/15, 11/24 5 temperatures were noter meal.  M, Dietary Staff L confirthe lack of temperature e monthly temperature department had new separatures of food item are recorded for each means are procedure, dated 3/22 ms must be cooked to emperatures, held and are of at least 135 degree that cold foods stay above 1 and cold foods stay beliaring the portioning, aring process until receivance.	ermed es logs, staff.  s will al. 2/13, ees low 41	F 371				